COX-2 Inhibitor Prior Authorization Request Form

To be completed and signed by the prescriber. To be used <u>only</u> for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP). Express Scripts is the TMOP contractor for DoD.

Your patient receives their prescription drug benefit from the Department of Defense (DoD). The DoD prescription drug benefit plan requires that we review certain requests for coverage with the prescribing physician. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage can be provided. **Before giving the prescription to the patient, please make a copy of this form, complete the following questions and give the completed form, along with the prescription, to the patient. Please instruct the patient to send this completed form, along with the prescription, to Express Scripts for processing.**

If Express-Scripts already has your patient's prescription and has requested that you complete this form, the completed form may be faxed to: (877) 895-1900 (toll-free) or (602) 586-3911 (commercial). A copy of this form and explanations of the underlying clinical rationale and criteria for approval are available at http://www.pec.ha.osd.mil/PA_Criteria_and_forms.htm.

Please designate drug for which Prior Authorization is requested:

- ☐ **Celecoxib (Celebrex®)**
- ☐ **Rofecoxib (Vioxx®)**
- ☐ **Valdecoxib (Bextra®)**

Step 1

Please complete patient and physician information (Please Print)

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Member #: ______________________ Phone #: ______________________

Secure Fax #:

Step 2

Please complete the clinical assessment

1. **Is this patient 65 years of age or older?** ☐ Yes ☐ No
   If yes, benefit is approved for 1 year. (Note: It is not necessary to submit a form to the TMOP for patients who are 65 or older. These patients will be automatically approved based on the age in their patient profile.)
   If no, proceed to Question 2.
2. **Is this drug being prescribed for treatment of familial adenomatous polyposis?** ☐ Yes ☐ No
   If yes, benefit is approved for 1 year.
   If no, proceed to Question 3.
3. **Is this drug being prescribed for the prevention or treatment of colon cancer or Alzheimer's disease?** ☐ Yes ☐ No
   If yes, benefit coverage is not approved.
   If no, proceed to Question 4.
4. **Will this patient receive Celebrex, Vioxx, or Bextra concurrently with another NSAID (non-steroidal anti-inflammatory drug), or with aspirin at a dose greater than 325 mg per day?** ☐ Yes ☐ No
   If yes, benefit coverage is not approved.
   If no, proceed to Question 5.
5. **Does this patient have a history of peptic ulcer disease, NSAID-related ulcer, clinically significant gastrointestinal bleeding, or an inherited or acquired coagulation defect (e.g., hemophilia, chronic hepatic failure)?** ☐ Yes ☐ No
6. **Has this patient failed an adequate trial with at least two (2) other different NSAIDs?** ☐ Yes ☐ No
7. **Is this patient receiving drug therapy with oral or injectable corticosteroids, anticoagulants, or antiplatelet agents?** ☐ Yes ☐ No

If the answer to one or more of Questions 5, 6, or 7 is yes, benefit is approved for 1 year. If not, benefit coverage is not approved.

Step 3

Please sign and date

______________________________ ______________

Prescriber Signature Date

Latest revision: April 2003